

Part B Insider (Multispecialty) Coding Alert

Chiropractic Services: Could Chiropractors Start Collecting for E/M Services?

CMS appears to be mulling the possibility.

Although chiropractors typically open each upcoming year's Medicare Physician Fee Schedule with a pessimistic eye, that could change. One feature of the 2014 proposal that may have caught your eye suggests that CMS is evaluating whether chiropractors should be able to provide and bill Medicare for E/M services.

Some patients do look to their chiropractor as a primary care physician and complain about many other ailments besides subluxations, so this would be great news for chiropractors if it came to fruition.

"We are not proposing to pay chiropractors for E/M services in CY 2014," CMS says in its proposed 2014 Fee Schedule. However, if after analyzing public comment, the agency believes it's a good idea, CMS "would do so in future rulemaking."

In addition, CMS estimates that chiropractors will see a two percent increase in pay for total allowed charges in 2014. This is a stark contrast to many other specialties that will actually see cuts next year if the proposals go through. For instance, as we reported in the Insider Vol. 14, no. 26, independent laboratories face a 26 percent projected cut, while radiation therapy centers would see a 13 percent drop in their Medicare pay next year.

Continue With CMT Billing

As CMS mulls over the possibility of chiropractic E/M pay, chiropractors should continue billing according to current CMS guidelines. As you may be aware, Medicare will not reimburse chiropractors for any service other than chiropractic manipulative treatment (CMT), which you'll bill using codes 98940-98942 (most Medicare carriers will not allow payment for extraspinal CMT [98943]). Section 2251 of the Medicare Carriers Manual (MCM) states, "Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, listing examples of manual manipulation as spine or spinal adjustment by manual means; spine or spinal manipulation; manual adjustment; and vertebral manipulation or adjustment."

Therefore, to avoid being singled out as a practice that incorrectly bills Medicare, ensure that you are reporting a code from the 98940-98942 range, and that your documentation supports the code with detailed notes indicating the exact procedure that you performed.

Ensure Subluxation Is in the Notes

In addition, Medicare and most private insurers require a diagnosis of subluxation of the spine to demonstrate medical necessity for CMT billing. Without it, your claim will still be denied, even if you report the appropriate CPT code.

You'll need to list two diagnostic codes on the claim to support medical necessity, says Part B MAC NHIC in its booklet, Chiropractic Billing Guide. "The level of subluxation must be specified on the claim and must be listed as the primary diagnosis," The guide indicates. This code will be in the 739.x ICD-9 range. In addition, "The associated neuromusculoskeletal condition necessitating the treatment must also be listed as the secondary diagnosis," the carrier adds.

A similar policy from Noridian Medicare, another Part B MAC, advises chiropractors to enter up to four diagnosis codes in priority order (two primary and two secondary conditions). "If you need to document more than four diagnosis codes, as will be the case any time there are more than two regions billed, the additional diagnoses must be present in the medical

record," the policy states.

Here's how: Suppose a patient presents with a subluxation of the lumbar and sacral spine with degeneration of disc(s) in the lumbar region, and the chiropractor performs CMT to the lumbar and sacral spine (one to two regions, 98940). You'll report 739.3 (Nonalopathic lesions of lumbar region, not elsewhere classified) as the primary diagnosis, followed by a secondary diagnosis of 722.52 (Degeneration of lumbar or lumbosacral intervertebral disc), and a tertiary diagnosis of 739.4 (Nonalopathic lesions of sacral region, not elsewhere classified).

In the past, Medicare required that chiropractors needed to have an x-ray that demonstrated the subluxation, but that is no longer required. Instead, you have to make sure you document all the essential features of your examination of the patient so you can demonstrate the diagnosis code choice.

In black and white: According to CMS Transmittal 137, dated April 9, 2004, "Effective for claims with dates of service on and after January 1, 2000, the x-ray is no longer required. However, the x-ray may still be used to demonstrate subluxation for claims processing purposes." In lieu of the x-ray, the transmittal indicates that the chiropractor must specify "the precise spinal location and level of subluxation giving rise to the diagnosis and symptoms" in the patient's record.

Resource: You can read the entire proposed 2014 Medicare Physician Fee Schedule at www.gpo.gov/fdsys/pkg/FR-2013-07-19/pdf/2013-16547.pdf.